have been enabled to witness in that brief period of time. Bacteriology has been one of the main factors in the great advance of medicine. From small beginnings, ridiculed and denounced, it has grown until it has become one of the most important branches of science, one to which we owe the discovery of the causes of many diseases, and to which we may confidently look for light on numerous dark places in our knowledge. Sanitary science has been quickened by it, and many branches of industry have been completely revolutionized. For the physician a knowledge of bacteriology is now almost as important as a knowledge of the urine. It is only necessary to mention the value of sputum examination and of the study of purulent exudates; the indispensability of bacteriology in the diagnosis and treatment of diphtheria, and the latest application of the science to the diagnosis of typhoid fever, Malta fever, etc. Whatever weapons the medicines of the future will possess against the infectious diseases it is most likely to receive from the hand of bacteriology. The literature of the science is enormous, and modern text-books are plentiful—our own countrymen have produced several of recognized value. The one before us is now in its second edition, and is a very satisfactory presentation of a limited part of the subject, that part, however, which is of the greatest practical importance, namely, the disease-producing bacteria. The book is divided into two sections—in the first, the author considers the biology of bacteria, immunity, sterilization, and disinfection, cultivation, and the bacterial examination of air, water, and soil. Part II. deals with the diseases produced by bacteria. A classification of these diseases is attempted, but cannot be called entirely satisfactory. Under present conditions it is, perhaps, wisest not to draw sharp dividing lines between toxic and inflammatory, or, as the author calls them, phlogistic diseases, or these and septic diseases. Some of the inflammatory affections are certainly toxic as well. The various diseases and their bacteria are discussed very fully and in a way that demonstrates the author's acquaintance with the literature. Malta fever and cerebro-spinal meningitis seem to have escaped mention. The living problems of bacteriology—immunity, antitoxins, etc.—are entertainingly considered. It might be well to include in future editions a brief chapter on the pathogenic yeasts.

The diction is superior to that commonly met in medical text-books.

The illustrations are numerous, and typographically the book is very attractive.

D. R.

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DISEASES OF THE EYE: A HANDBOOK OF OPHTHALMIC PRACTICE FOR STUDENTS AND PRACTITIONERS. By G. E. DE SCHWEINITZ, A.M., M.D., with 255 illustrations and 2 chromo-lithographic plates. Third edition, thoroughly revised. Philadelphia: W. B. Saunders.

IN presenting the third edition of this excellent text-book the author states in his preface that "particular attention has been given to the important relations which micro-organisms bear to many ocular disorders." The frequent references which are encountered in the text show that the author has kept himself well informed, and has utilized to the best purpose the rapid progress of ophthalmology. The work will undoubtedly continue to be one of the most popular text-books on diseases of the eye for both students and practitoners. W. C. P.

can bring on an attack, in the second group the fits are not so readily brought on, but in the periodic dilatation alcohol is likely to bring on severe attacks. 3. Recovery is possible only after complete abstinence, but is accelerated by remedies that strengthen the heart muscles.

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**Hysterical Diaphragmatic Asthma.**—E. BARTH (*Berliner klin. Wochenschrift*, 1898, Nos. 42 and 43) reports the case of a non-commissioned officer who suddenly became dyspnœic, and gradually grew worse, so that he was unable to remain on duty. There was no previous history of importance, except that about a year before the patient lost his voice for two weeks, apparently as the result of overuse in drilling. The patient was pale, but without cyanosis or œdema. The dyspnœa was very striking, being both inspiratory and expiratory, and with only five or six respirations per minute. The patient complained of shortness of breath and pain in the thorax and abdomen. The lungs were overdistended, but without ausculatory abnormalities. There was neither cough nor expectoration. The nose, pharynx, and larynx showed no alterations of importance. The pulse was small and weak, the heart-sounds weak and impure, and the case seemed at first one of cardiac asthma. It soon appeared that this view was not in accord with the absence of cyanosis, the freedom from anxiety, the activity of voluntary motion, and the relative absence of asthma when the patient thought himself not observed. At times the patient complained of "palpitation of the heart," but this proved to be a clonic spasm of the diaphragm, in which twenty to twenty-five contractions were followed by a pause, the whole attack sometimes lasting many hours. Along with this there were tonic and clonic spasms of the orbicularis oris and the sphincter of the eyelids. How long the condition had lasted before admission could not be learned, but after two weeks in the hospital it suddenly passed over into complete paralysis of the diaphragm. The lungs retracted to their normal volume; the heart-sounds became pure; the dyspnœa continued. Inspiration was forced, but expiration was easy, and gave the patient slight relief. Faradization of the phrenics and practice in voluntary respiration were soon followed by improvement, but the dyspnœic motions returned whenever the patient felt he was being observed. Finally, complete recovery was obtained, and in the four months since then there was no relapse. A résumé of the author's comments is hardly necessary. He quotes largely from the work of Wernicke on hysterical dyspnœa from faulty innervation of the phrenics (*Monatsschrift f. Psychiat. u. Neurologie*, 1898, p. 200). In accordance with the modern tendency in Germany, the attack is explained as possibly due to overexertion of the respiratory organs, and the overexertion of the adductors of the larynx in giving commands is suggested as the probable cause of the previous aphonia!

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**A Case of Cheiromegaly in Syringomyelia.**—LUNZ (*Deutsche med. Wochenschrift*, 1898, No. 41) reports the following: A woman, aged thirty years, with a negative family history, began to have epileptic attacks at sixteen. Three years ago pains began in the right wrist and hand, shooting out to both sides. At the same time there were chilly sensations, and the patient frequently burnt her hand by trying to get it warm. About the same time the right hand began to increase in size. For a year there have been pains and a feeling of chilliness in the left arm, back, and breast. The right arm, hand, and fingers are now considerably larger in all parts than the left, the increase being partly due to the soft parts and partly to the bone, as confirmed by the X-rays. The tactile sensibility is normal, as is also the sense of position and pressure and the muscular sense, but there is complete analgesia and loss of temperature-sense (ice and 40° C. cannot be distinguished) in the neck, back of the head and shoulders, the back to the ninth dorsal vertebra, the chest to the lower end of the sternum, and both upper extremities. There is no paralysis in the arms, but the strength is reduced in both, especially the right. The reflexes are lowered in the upper extremities, the knee-jerk increased, especially the right. Faradic reaction of muscles and nerves is lowered in the upper extremities. The absence of muscular atrophy is interesting. The changes in the bone as observed by the X-rays are like those described by Schlesinger in acromegaly.

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**Melanoplakia of the Mucous Membrane of the Mouth and the Diagnosis of Addison's Disease.**—FR. SCHULTZE (*Deutsche med. Wochenschrift*, 1898, No. 46) calls renewed attention to pigmentation of the mucous membrane of the mouth, occurring in certain chronic diseases, especially cancer of the stomach. Stomatitis, cirrhosis of the liver, and jaundice may also be followed by pigmentation in the mouth that may excite the suspicion of Addison's disease. He describes a case in which there were discolorations in the skin and blackish spots on the soft and hard palate and gums. There was ascites, with reddish-yellow fluid of specific gravity 1017 in the peritoneal fluid. The spleen was enlarged. Tuberculosis, cirrhosis of the liver, and Addison's disease seemed possible, yet the patient was observed for seventeen months without other signs of that affection. In another case there was an old history of biliary colic, later irregular and intermittent fever, with chills, and jaundice. The skin showed brownish or yellowish discolorations (not jaundice), and there were grayish-brown areas in the mouth, with atrophy of the mucous membrane in the pigmented parts. Dulness over the left apex, with moist râles, strengthened the suspicion of tuberculosis and Addison's disease. The patient gained in weight, but later had a recurrence of biliary colic. An operation revealed extensive adhesions around the gall-ducts and gallstones, with small foci of suppuration. The patient recovered, but later had tuberculous epididymitis and orchitis, for which he was successfully operated. The author also describes a case with the asthenic symptoms of Addison's disease, but without discoloration, in which the autopsy showed only gastro-intestinal atrophy. [That pigmentation of the mucous membrane of the mouth is not a certain sign of Addison's disease will hardly be denied. On the other hand, the chronic course and partial improvement in the cases cited do not exclude Addison's.—ED.]

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**The Dyspepsia in the Early Stage of Pulmonary Tuberculosis.**—W. CRONER (*Deutsche med. Wochenschrift*, 1898, No. 48) has investigated this subject by examinations not only on persons with gastric symptoms, but also in those in whom accidental dyspepsia, as from fever and alcoholism, might be excluded. There was nothing characteristic about the symptoms of tuberculous dyspepsia—eructations, a feeling of pressure in the epigastrium, succussion above the umbilicus, and irregular defecation being the most common. Dilatation of the stomach was not demonstrable in any case, and gastroptosis was rare and never severe. In no case was the motor power notably lessened. The chemical results varied greatly. The total acidity varied from 21 to 80, in most cases was about normal, but more frequently below than above. In only five out of thirty-six cases was HCl absent. It was not possible to find any relation between the chemical conditions and the symptoms. The author discusses the various explanations of the gastric alterations found, such as fever, swallowed sputum, anæmia, chronic gastritis, etc., and comes to the conclusion that the alterations are functional. The variable reactions and the inconstancy of the symptoms point to the same thing. The author also refutes the idea that the gastric symptoms of early phthisis are due to overfeeding in any considerable proportion of cases.

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**Disease of the Pancreas in Hereditary Lues.**—According to SCHLESINGER (*Virchow's Archiv*, Band cxliv., Heft 3, S. 501) syphilitic involvement of the pancreas is rare in acquired lues. But few are recorded in the literature. On the other hand, the pancreas is comparatively frequently involved in inherited lues in the new-born child and in infants. This fact was first emphasized by Birch-Hirschfeld in 1875. He found the pancreas more or less extensively involved in thirteen cases out of a total of twenty-three autopsies on fœtuses or infants with hereditary lues. Since 1875 no observer has found the pancreas diseased in such a large percentage of cases. Birch-Hirschfeld published a second series of cases in 1880, in which he found the pancreas involved twenty-nine times in a total of 124 cases. Since Birch-Hirschfeld's first publication there has been no accurate study of disease of the pancreas in hereditary lues, and, for this reason, Schlesinger undertook the study of the gland, paying special attention to the histological changes produced.

Schlesinger draws the following conclusions from his study:

1. In hereditary lues the pancreas is less frequently involved than the spleen, liver, bones, and lungs, but oftener than the thymus, heart, or intestine.

2. Contrary to the view formerly held that the pancreas became involved only in the later months of fœtal life, it may become diseased as early or as late in intra-uterine life as do the other organs.

3. There is no close relationship between syphilis of the pancreas and coexistent disease of other organs. In exceptional cases the duodenum is diseased, and then both the pancreas and liver are usually involved.

4. Macroscopically, the first change in the pancreas is its increase in consistence and then its increase in size. The gland may become cartilaginous in its hardness, the head becoming more extensively involved than the tail.

5. Adhesions between the gland and adjacent organs are common.

6. The lesion is a diffuse interstitial pancreatitis, involving first the interlobular, then the interacinous, and finally the intercellular connective tissue. This process may be so extensive as to destroy completely the glandular portion proper.

7. No degenerative changes accompany the atrophy.

8. The connective tissue proliferation nearly always commences about the bloodvessels, rarely about the excretory ducts.

9. Syphilitic gummata are rare in pancreas in hereditary lues of infants as compared with their frequency in acquired syphilis.

10. The large and small ducts rarely show proliferation of the connective tissue about them.

11. Of the vascular changes pericarditis and endarteritis of the interlobular vessels and destruction of the periacinous capillary network are the chief ones.

12. The intertubular collections of cells, which are more abuandant in children than in men, were not involved in the connective-tissue proliferation nor in the atrophy of the parenchyma.

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**The True Function of the Thymus.**—J. BEARD (*The Lancet*, January 21, 1899, p. 144) made an exhaustive study of the thymus gland, using the thymus of one of the vertebrates, Raia batis, the smooth skate. Since Kölliker discovered that the thymus originates in mammals from the epithelium of a gill-pouch, and since he stated the original epithelial cells gave rise to lymph cells or leucocytes, two views have been entertained regarding the function of the gland. Stieda and His maintain that the leucocytes which always form an integral part of the gland soon after its formation are not produced in the gland, but migrate thither, probably from the mesoblast. According to these observers Hassal's concentric corpuscles are supposed to be formed from the original epithelial cells, and the function of the gland is still absolutely unknown. Stieda and His made no attempt to associate the Hassal corpuscles with the origin of the leucocytes. Kölliker first discovered that for a relatively long period of fœtal development the blood contained only nucleated red corpuscles and no leucocytes whatever. H. E. Ziegler ventured the opinion that this condition persisted until some lymphoid organ developed.

In studying the thymus of the smooth skate in sections of embryos 17 to 22 mm., Beard was able to demonstrate quite easily the transformation of the epithelial cells of the thymus into leucocytes. A one-eighteenth Zeitz oil immersion lens was used. The first change in the epithelial cell is one in its protoplasm or cytoplasm. This becomes somewhat more refractive, and in favorable sections takes on a somewhat brownish tinge. At first no alteration can be noticed in the nucleus, which is oval as in the other epithelial cells. Then it becomes rounded, and gradually the whole cell acquires this shape. With this and the marked refractile nature of the protoplasm the cell, according to Beard, takes on the characters of a leucocyte. These leucocytes for a time remain within the mass of epithelial cells, and later can be seen to migrate one by one into the mesoblast and elsewhere. He states that these cells do not wander into the epithelium of the thymus, because until some are formed within the latter there is no source in the body whence they could be derived. In embryos 22 mm. in length a few leucocytes are found in the blood itself. Beard holds that the absence of leucocytes in the earliest period of embryonic blood in vertebrates persists until the first ones are formed within the thymus-epithelium, and from its epithelial cells. In embryos from 28 to 42 mm. long the formation and emigration of leucocytes from the thymus becomes very active, and at this time there is no part of the embryo, including the blood, that is not infiltrated with leucocytes. This happens before lymphoid structures are developed elsewhere within the body of the smooth skate. Beard, then, believes with Kölliker that the formation of leucocytes is a function of the thymus gland. As a result of his work, he thinks that he has definitely provéd that not only does the thymus form leucocytes, but that it is the parent source of all the leucocytes of the body.

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**Treatment of Obesity with Thyroid Preparations.**—EBSTEIN (*Deutsche med. Woch.*, 1899, No. 1, p. 1; No. 2, p. 23) reviews the history of the administration of thyroid preparations in the treatment of obesity, and credits Yorke-Davies with its introduction for this purpose. He refers to the popularity of the treatment in England, and the warning which Burroughs, Wellcome & Co., the manufacturers of the tablets, gave against the abuse of the treatment by the laity, when the administration of the drug is not supervised by a physician. Without such supervision the possibility of thyroidism and other dangers is considerable. The treatment was advocated in Germany first by Leichtenstern and Wendelstadt, who claimed excellent results for it.

Ebstein declares strongly against the thyroid treatment of obesity. He published the records of seven cases in which he had followed this treatment in the Göttingen clinic. In all the cases there was a slight reduction in the body-weight, but not more than could be obtained by proper dieting.

Ebstein gives the following reasons against the use of the thyroid treatment: 1. The results obtained are unsatisfactory, because the diminution in weight is not constant, and may not occur at all. The diminution in weight frequently ceases, even when the thyroid preparation is being administered or shortly after it is stopped. There is no improvement in the patient's subjective feelings under the treatment.

2. The treatment is not a rational one. The ideal treatment is the one where only the fat is lost. In the thyroid treatment there is waste of the body albumin as well, as the studies in metabolism have shown.

3. Any improvement following the administration of thyroid preparations can be obtained with less danger by proper dieting.

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**Acute Diffuse Myocarditis.**—G. FREUND calls attention to the difficulty of diagnosis in acute purulent myocarditis and the frequency with which it is associated with rheumatism and diseases of the joints. In his case the process developed during an attack of subacute rheumatism. The clinical symptoms were not very clear. In the beginning the mental symptoms suggested salicylic-acid poisoning, but on discontinuing the drug there was no change. The increasing paleness, the large size and hardness of the spleen, and the pain under the sternum suggested leukæmia, but the blood examination was negative. A cerebral affection, especially meningitis, was considered, but discarded as the result of negative lumbar puncture. Because of association with rheumatism, and the presence of a normal temperature, with dull heart-sounds, a diagnosis of endocarditis was made. The author cites a number of cases from the literature in which acute purulent myocarditis was proved post-mortem to be associated with or a sequel of rheumatism and diseases of the joints. The signs and symptoms often are so contradictory in different cases that it is impossible to lay down rules for diagnosis. The differentiation from endocarditis and pericarditis is most difficult. The persistent pain in the præcordia has been mentioned by many observers, and is often associated with a feeling of anxiety in contrast to the absence of other threatening symptoms. The exclusion of endocarditis and pericarditis is always essential.—*Berliner klin. Wochenschrift*, 1898, Nos. 49 and 50.

**Typhoid Fever and Trichinosis.**—H. FISCHER (*Deutsche med. Wochenschrift*, 1898, No. 52) reports an old observation, being the case of a young butcher who developed typhoid fever and trichinosis simultaneously. Two days after eating excessively of raw tainted meat he had chills, loss of appetite, pains, and great weakness of the limbs. Six days later he was admitted to the hospital with all the signs of a severe typhoid. A large bed-sore developed over the sacrum. On removing the gangrenous tissue a piece of healthy muscle was accidentally cut away, which even to the naked eye appeared thickly studded with trichinæ. Microscopical examination showed the trichinæ to be very near each other and encapsulated, the capsules still transparent, and the parasites very lively. The patient died of pneumopleuritis. The autopsy showed the typical lesions of typhoid fever in the ileum. There were many trichinæ in all of the muscles. The clinical signs of trichinosis were unimportant, those of typhoid fever dominating the clinical picture. Neither œdema nor stiffness of the muscles was observed. The trichinæ grew and increased undisturbed by the high septic fever or the changes in nutrition and structure of the muscles caused by the typhoid fever.

**Peptic Duodenal Ulcer.**—In opposition to the generally accepted opinion BURWINKEL (*Deutsche med. Wochenschrift*, 1898, No. 52) contends that it is possible to differentiate duodenal ulcer, *intra vitam*, from round ulcer of the stomach, and adds to the eight and five cases reported by Chvostek and Boucquoy, respectively, five of his own. All the patients gave a history of long-continued bending over while at work. In four there was a family history of tuberculosis, and in the fifth it could be looked on as probable. His diagnoses, however, were not confirmed by autopsy. The points upon which he based his diagnosis are the following: 1. Melæna not to be explained by tuberculosis, cancer, or "essential" intestinal hemorrhage. The actual hemorrhage is often associated with syncope and vomiting, with no blood in the vomitus 2. The seat of the pain is not always in the right hypochondrium, as has been supposed, but at times in the region of the navel, or between that and the right costal border. The pain does not radiate to the back, as in gastric ulcer, and usually appears two or three hours after meals, or later, if the gastric digestion is delayed. 3. In all the cases there is a history of prolonged dyspepsia, in which the symptoms of ulcer appear at intervals. In the dyspepsia constipation is the rule, but the tongue is rarely so coated as in chronic gastritis, and there is no *fœtor ex ore*. The appetite is retained, even in the attacks—a fact that has been used to explain the speedy improvement in many cases. Icterus is rarely pronounced, and probably occurs only when the ulcer is near the orifice of the common duct. 4. Duodenal ulcer often affects men in the prime of life—strong and robust, and, in most of the author's cases, careful in their mode of life. The author's remarks on prognosis and treatment present nothing new.

**The Coincidence of Bitemporal Hemianopsia and Diabetes Insipidus.**—Spanbock and Steinhaus have investigated this subject, concerning which it has been assumed by many that there is a frequent association, yet the anatomical basis of which is, *a priori*, difficult to understand. Out of some fifty cases of temporal hemianopsia polyuria has been noted in eleven. In six of these there is no clinical evidence of the existence of diabetes insipidus. In four more the bitemporal hemianopsia is not conclusively demonstrated, and the symptoms point to wide-spread lesions of the brain. There remains only the case of David, in which the hemianopsia, though not entirely pure, was present with normal eye-grounds, and repeated examinations put the diagnosis of diabetes insipidus beyond doubt.

The authors add a case of their own. This was in the case of a married woman, aged thiry-three years, syphilitic. Polyuria and polydipsia appeared, soon followed by loss of vision in the temporal fields. Examination showed a typical bitemporal hemianopsia. The urine amounted to six litres in twenty-four hours, specific gravity 1003, pale and clear, without sugar or albumin. A diagnosis of syphilitic disease in the floor of the fourth ventricle and the optic chiasm was made, and treatment with injections of mercury sozojodolate, with large doses of potassium iodide, begun. After the third injection the eye-symptoms improved, and after the fourth they disappeared, though the diabetes persisted. Still later the latter ceased, and the patient regained her former weight and health. From this case the authors conclude that the combination of diabetes insipidus and hemianopsia is purely accidental, and that the course in any case will depend on the nature of the lesions concerned and the possibility, as in their case, of successful treatment.—*Deutsche med. Wochenschrift*, 1898, No. 52.

# PEDIATRICS.

UNDER THE CHARGE OF

LOUIS STARR, M.D.,
OF PHILADELPHIA,

AND

THOMPSON S. WESTCOTT, M.D.,
OF PHILADELPHIA.

**Classification of the Anæmias of Infancy.**—John L. Morse (*Archives of Pediatrics*, November, 1898, p. 815) reports a marked case of anæmia in a child of ten months, characterized by enlargement of the liver, spleen, and glands, with moderate increase in the number of leucocytes, poikilocytosis, and a great preponderance of large, nucleated forms, suggesting a pernicious anæmia. The diminution in the number of red cells was slight, however, and much less than that which usually occurs in this condition. The increase in leucocytes was moderate, being much less than that which usually occurs in leukæmia, which disease was suggested by the enlargement of the liver, spleen, and glands. The clinical history and blood condition corresponded pretty closely to those of "anæmia infantum pseudo-leukæmica," as described by Luzet and Alt and Weiss. This condition, however, the author thinks cannot be considered as a disease *sui generis*, but merely as a severe form of secondary anæmia with leucocytosis, and under this head he classes the case described, which he considers simply as an example of a large and irregular class of cases. The cause of the anæmia in his case was undoubtedly to be sought in general malnutrition resulting from improper food; while the splenic tumor was regarded as a mere coincidence, a result of the same cause, as shown by the fact that it became smaller as the case progressed, and probably finally disappeared altogether.

He refers to the difficulty in classifying the anæmias of children owing to the tendency to exaggeration of changes and to reversion to a younger or to a fœtal type of blood; to the frequency of splenic enlargement in all forms of blood disease in infancy; to the greater rapidity and degree in which leucocytosis develops in children, and to the fact that myeloycetes occur in less severe conditions and in greater numbers than in adults, and that the percentage of hæmoglobin is almost always relatively low. For these reasons he believes that only a very simple classification is justifiable in the light of our present knowledge, and he suggests the following modification of Monti's as a fairly satisfactory one: *Secondary*—Mild anæmia, mild anæmia with leucocytosis, severe anæmia, and severe anæmia with leucocytosis. *Primary*—Pernicious anæmia, leukæmia. In all these forms there may be greater or less splenic enlargement. Splenic tumor, therefore, is of little or no aid in the differential diagnosis of the anæmias of infancy. Under the head of severe anæmia with leucocytosis, he thinks, for the present, must be included all those anomalous cases which do not correspond to the type of either pernicious anæmia or leukæmia, and in this class he includes the cases which have hitherto been described as anæmia infantum pseudo-leukæmica.

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**Cyclic Vomiting.**—H. B. WHITNEY (*Archives of Pediatrics*, November, 1898, p. 839) details a typical case and reviews the literature of the subject, starting with Leyden's description under the head of periodical vomiting, which appeared in 1882. The affection is rare. It is often very severe, and attacks come on without discoverable cause and persist for from twelve hours to four or five days. These gastric crises occur at intervals of from six weeks to six months. In the author's case an interval of three months was observed between attacks occurring over a period of a year, excepting one interval of two months, and in several instances they fell upon the same day of the month. Pathologically, the affection seems to be a gastric neurosis. In certain cases migrainous attacks have alternated with those of the purely gastric condition, and Rachford has observed a gradual transition with advancing youth from early cyclic vomiting to a definite migraine. It is interesting to observe that Rachford has found a large excess of poisonous alloxuric bodies, particularly paraxanthin and heteroxanthin, in the urine of persons suffering from such crises as those of migraine and periodical vomiting.

Whether or not this affection is lithæmic in character, it is certain that there are important predisposing factors, among which are early age. In most cases, also, there is probably a decided neurotic taint, either in the child's past history or in his parentage. It was so in Rachford's cases, and in the one reported by the author the child was thin, nervous, and rather precocious, with gout, migraine, tuberculosis, and insanity in its immediate ancestry. Treatment embraces general hygienic measures, the use of large quantities of fluid, especially milk, and some one of the various lithia waters, with salol or salicylic acid, and the maintenance of an active condition of the bowels.

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**Unusual Complications of Epidemic Parotitis.**—W. ZINN (*Centralblatt f. die med. Wissenschaften*, 1898, No. 51) reports two cases that show that inflammation of serous membranes may occur occasionally in the course of this disease. In the first case, a school-boy, aged thirteen years, there developed during the course of the disease high temperature and endocarditis, with signs of mitral insufficiency. The symptoms became insignificant after the subsidence of the disease. The second patient, a man, aged twenty-two years, when first examined presented high fever, diarrhœa, and symptoms of peritonitis. On the seventh day double parotitis developed, and with resolution the abdominal symptoms disappeared.

A severe acute nephritis was reported recently by C. G. KERLEY (*Archives of Pediatrics*, February, 1898), beginning on the sixth day of an attack of mumps in a boy aged four years. Under appropriate treatment the urine became normal at the end of six days.

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**The Value of Metallic Percussion Combined with Auscultation in the Diagnosis of Pleural Effusion in Children.**—MOUSSOUS (*Revue mensuelle des Maladies de l'Enfance*, January, 1899, p. 1) calls attention to metallic percussion with auscultation (the coin-test) in the diagnosis of pleural effusions in children, and considers it a most valuable means in distinguishing between the dulness due to pleural effusion and that depending upon pulmonary consolidation.

The value of the coin-test in adult patients in conditions other than pneumothorax has already been investigated by Pitres, and later by his pupil, Sieur. Their observations have shown that when the lung is healthy the sound transmitted to the ausculting ear is obscured, smothered, and without metallic timbre. In the presence of a liquid effusion, however, whether it be serous, fibrinous, purulent, or sanguineous, formed in a pleural cavity free from adhesions, the transmitted sound has a clear, sharp, metallic ring.

Ordinary congestions of the lung and the ordinary inflammatory or neoplastic indurations fail to give the coin-test in its purity. The same is true of broncho-pneumonic foci, hæmoptoic infarcts, tuberculous infiltrations, and even encysted pleurisies and liquid effusions of the pericardium. Not only may the presence of fluid thus be recognized, but also the upper limit of the effusion in pleuro-pneumonia and the portion of the zone of dulness which corresponds with the effusion in pleurisies with false membrane. The author has devoted several years to study of this test as applied to young infants with the hope of proving its value in a class of cases which offers greater difficulties in diagnosis than do similar conditions in the adult, and has demonstrated to his satisfaction that this test constitutes a very valuable addition to the ordinary methods of diagnosis.